DOCKERY & ASSOCIATES
PHYSICAL THERAPY

I hereby consent to a physical therapy examination and subsequent treatment as recommended by the examining physical therapist.

Examination. I understand the examination includes providing a medical, social and physical activity history and reporting of my symptoms and complaints. I agree to allow the physical therapist to perform all physical tests and measures required to identify my physical therapy diagnosis, problems and prognosis. I understand that some tests and measures may require the physical therapist to perform a visual inspection of exposed body areas or palpate body parts that are sensitive or painful. I also understand that there are some risks in participating in a physical examination, including but not limited to developing soreness, increased pain, new pain in different areas, an aggravation of existing symptoms or a new injury. I understand that if I am uncomfortable at any time during the examination, I can let the therapist know and may refuse to continue the examination at my choice. If I refuse to participate in any part of the examination, I understand that the physical therapist may not be able to provide an accurate physical therapy diagnosis/prognosis or develop the most appropriate treatment plan.

Treatment. I acknowledge that my physical therapist (hereinafter "PT") has informed me of my diagnosis, prognosis and the potential risks and benefits of all recommended interventions in my proposed plan of care and I have been given an opportunity to have all my questions answered. I hereby agree to participate in and consent to receive the physical therapy interventions recommended by my PT as outlined in my treatment plan. I understand that the response to different physical therapy interventions varies from person to person and sometimes treatment interventions may result in increased pain, an aggravation of existing symptoms or a new injury. Therefore, I agree to inform my PT of any change in my symptoms and function so my treatment plan can be adjusted accordingly. I understand that I may decline any intervention at any time by informing my PT of my desires/concerns and that my refusal may result in a termination of my treatment if my PT determines that there are no other treatment alternatives or the refused intervention is essential to meeting my goals. I also understand that although we have set rehabilitation goals, my PT has made no guarantees that any particular outcomes will result from the therapy interventions.

I have read and understand the benefits and risks involved in participating in a physical therapy examination and treatment. I consent to the examination and treatment, accept any and all associated risks involved and agree to fully cooperate and participate in the proposed physical therapy interventions in the established plan of care.

Our Right to Discontinue Services. We reserve the right to discontinue services at any time if, at our discretion, we believe the services you are requesting are not appropriate for your condition or you display inappropriate behavior during a treatment/wellness session. If we discontinue a session because of any inappropriate behavior on your part, you will not be entitled to a refund.

Acknowledgement Notice Of Privacy Practices: Under federal HIPPA guidelines, all patients are to be provided with the opportunity to review and/or have a copy of our Notice of Privacy Practices which explains how medical information will be used and disclosed. By my signature below I acknowledge having been made aware there is a copy in our facility, on our website. and I may obtain a hard copy from Dockery & Associates Physical Therapy, if desired.

Worker's Compensation Patients: I authorize the release of all medical information to my Employer, Insurance Adjuster and/or Case Manager assigned to my Worker's Compensation Claim. I further understand that if I am non-compliant with my treatment program and/or appointments that Dockery & Associates Physical Therapy may notify the above stated individuals.

Release of Records: I authorize Dockery & Associates Physical Therapy to disclose all or part of my medical and/or patient account records to my insurance company or association as may be necessary for the processing of any outstanding insurance claims, as well as to any treating physician or healthcare providers involved in my, or my child's, medical care to include copies of medical records.

Communication Consent: I expressly consent and authorize Dockery & Associates Physical Therapy to communicate with me for any reason, including reasons related to the services provided by Dockery & Associates Physical Therapy or services to be provided in the future by Dockery & Associates Physical Therapy, including collection of amounts owed for said services, via communications at the telephone number or numbers I provide, or that is provided on my behalf, or any phone number, or other forms of communication that Dockery & Associates Physical Therapy obtains or finds on its own which is not provided by me. Until my accounts are settled, I give my consent to receive communications regarding my account from any servicers and collectors of my accounts through various means such as cell, landline, text, email, auto dialer systems, voicemail messages or other forms of communication.

Patient's Name (Printed) _____

Patient's Signature _____ Date_____

Parent/Guardian Signature_____ Date_____